

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

DIVISION OF HEALTH PROFESSIONS

Board of Medicine

121 South Fruit Street, Suite 301

Concord, N.H. 03301-2412

Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director



REINSTATEMENT APPLICATION GENERAL INFORMATION

All applicants for reinstatement of license must complete and submit a Board application.

Board Application Process

You must submit information directly to the Board. The Board will use this information to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. **You are responsible for notifying the Board office, in writing, if your address changes in the interim.**

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to completing the Board application. If you have questions about this application process, or would like to check on the status of your Board application, please call the Board at (603) 271-6935.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. All documents you submit must be originals, signed on letterhead unless notarized copies are specifically authorized.
5. You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST. With the acknowledgement letter, you will receive paperwork to complete a criminal background check. **Pursuant to RSA 329:11-a, you are required to submit a notarized criminal history record release form, along with a fee, which authorizes the release of your criminal history record, if any, to the Board. This form will be provided to you with your acknowledgment letter once your application has been received by the Board.**

Completing your Application

1. Complete the Board Application (pages 4-7). You must respond to all components of the application. If you answer "Yes" to any of the questions on pages 5-6, you must attach a written explanation on the reverse side of the sheet or attach a separate 8½" x 11" sheet, if necessary.

Make a check or postal or express money order (in U.S. funds only) for the application fee of **\$350.00** payable to: Treasurer, State of New Hampshire and staple it to the upper left-hand corner of the first page of the application. This application fee is NON-REFUNDABLE.

2. Complete page 7, "Affidavit of Applicant." The affidavit must be signed in the presence of a notary and must have a 2"x2" recent "passport" photograph of you securely affixed to the form.
3. Complete page 8, "Report of Medical Malpractice Claims or Suits Filed," if applicable. You must use this form to report all claims or suits for medical malpractice made against you. The report should be completed in its entirety. Make additional copies of this page as necessary for multiple claims.
4. Obtain a total of four (4) letters of reference attesting to your moral character and professional abilities. These letters must be obtained from the following: the chief of staff (ref. 1) and hospital administrator (ref. 2) in a hospital where you presently hold staff privileges (if no staff privileges are presently held, letters of recommendation shall be submitted by 2 other practicing medical doctors who hold hospital staff privileges); and two (2) additional letters of reference from practicing physicians. **Reference letters must be originals submitted on letterhead. References may be submitted by the applicant or by the physician providing the reference.**
5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.
6. Submit your curriculum vitae.
7. Submit a notarized copy of your current Drug Enforcement Administration (DEA) certificate.
8. Prepare all application materials as instructed and arrange them in the order as they appear above

in steps 1-7. Do not submit applications without all applicable information and documentation. Mail your application to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD, NEW HAMPSHIRE 03301-2412

9. Submit proof of completion of continuing education which meets the requirements of Med 402.01. Please call or write to Mary West, New Hampshire Medical Society, 7 North State Street, Concord, NH 03301 (603) 224-1909, to inform her of your reinstatement and request the proper forms for filing CME credits.
10. Obtain verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail page 10, "Release of Information from Other Licensing Authorities," to each licensing authority in which you are/were licensed. Be certain to sign and complete the identifying information on each form. **These verifications must be received directly from the licensing authority.** You may obtain the mailing address of all 68 medical licensing authorities at the Federation of State Medical Boards' website at www.fsmb.org, or by calling the Board in question. Most states charge a fee for verification of licensure. To save time, you should check with the state board before submitting your request. Please do not contact the New Hampshire Board for mailing addresses of other licensing authorities.

Other Information

Your application process is not considered complete until your Board application and licensure verification(s) are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed at the first available Board meeting. Please allow 7-10 working days following the Board meeting for your license to be mailed to you.

Note: Do NOT make commitments to start practicing medicine in New Hampshire until you have been issued a license.

New Hampshire Board of Medicine
PHYSICIAN REINSTATEMENT APPLICATION

Staple your application fee of \$350.00 to the upper left-hand corner of this page.

Name (as it will appear on your medical license):

Last Name (include Maiden Name, if applicable) Gen. Suffix

First Name Middle Name

Office Name: _____

Office Address: _____
Number and Street Apartment Number

City State Zip (or postal) Code

Home Address (where all Board correspondence will be sent):

Number and Street Apartment Number

City State Zip (or postal) Code

Telephone Numbers

Business: (____) _____ Home: (____) _____

Other: (____) _____ Fax: (____) _____

E-Mail Address: _____

Identifying Information

Date of Birth: _____ Place of Birth _____
Month Day Year City State

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

Social Security Number: _____-_____-_____

For Board Use Only:

Application Received: _____ 20 _____ Fee Paid: _____ Check#: _____

License Number: _____ Date of Issue: _____

Application for Reinstatement of Licensure (continued)

List all states where you hold or have ever held a license to practice medicine. **Please continue list on back of this page if needed.**

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please answer the following questions. If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.

	YES	NO
1. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	_____	_____
2. Have you ever, for any reason, lost American Specialty Board Certification?	_____	_____
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).	_____	_____
4. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).	_____	_____
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	_____	_____
6. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?	_____	_____
7. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? You must report all exam failures, even if you later passed the examination. (This does not include specialty board certification examinations.)	_____	_____
8. Have you ever failed a foreign licensing or certification examination?	_____	_____
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	_____	_____
10. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?	_____	_____

11. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

12. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?

13. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?

14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?

15. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?

16. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?

Anticipated Practice Location(s) (if known):

I, _____
(type/print your complete name)

hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or as a Doctor of Osteopathy and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclosed a check or postal or express money order for the application fee of \$350.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. In doing so, I hereby release, discharge, and hold harmless the State of New Hampshire, the Board of Medicine, its agents or representatives and any person furnishing information, records, or documents of any and all liability.

Typed/Printed Last Name First Name Middle Name

Applicant's Signature Date of Signature

AFFIDAVIT OF THE APPLICANT

STATE OF _____
(where applicant resides)

COUNTY OF _____
(where applicant resides)

I, _____ of _____
(Applicant's Name) (City and State where Applicant Resides)

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the State of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age and licenses, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Applicant's Photograph

Paste a recent passport photograph
of yourself here.

Applicant's Signature

Last Name

First Name

Middle Name

Date of Signature

Sworn to before me this _____ day of _____, 20____

Notary Public signature

Date Commission Expires:

[Affix Seal Here]

REPORT OF MEDICAL MALPRACTICE CLAIMS OR SUITS FILED

Please use this form to report all claims or suits for medical malpractice made against you. The report should be completed in its entirety. Make additional copies of this report as necessary for multiple claims.

NAME OF CLAIMANT _____

NAME OF DEFENDANT _____

NEW CLAIM OR SUIT _____ DATE FILED OR OPENED _____

COURT NAME _____

NAME OF INSURANCE COMPANY _____

DOCKET #: _____ CLAIM #: _____

DATE OF INCIDENT _____

CURRENT LEGAL STATUS _____

GENERAL NATURE OF CLAIM _____

Signature: _____

Date: _____

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice medicine in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD, NEW HAMPSHIRE 03301-2412
Tel: (603) 271-1203

Biographic Information:

Last Name	First Name	Middle Name	Gen. Suffix
Mailing Address		City	State
			Zip Code
Social Security Number:		Date of Birth:	
License Number (if known)		Signature	

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official
Board
seal here

Signature/Title

Date